Congress wanted more time to study the health care bill, so we held off on voting until after August. This issue affects every American and is key to putting our country on the path to long-term economic stability. I'm pleased that we have more time.

However, a lot of groups are using this time to spend millions of dollars to spread harmful myths designed to confuse and frighten you. I'd like to set the record straight on a few of the myths I hear the most.

1. Reforming health care will not lead to out of control deficit spending. The bill is paid for. Half of the bill is paid for in health care sector savings and half through a new surcharge on the richest 1% of Americans. Doing nothing, however, will lead to bigger deficits that will eat our budget alive.

2. This legislation will not insure illegal aliens. Here is the exact language in the bill: "Nothing in this subtitle shall allow Federal payments for affordability credits on behalf of individuals who are not lawfully present in the United States."

3. This legislation will not create a government-run health care system. If you have employer-based private health care, and you like it, keep it. It will remain private and you will keep your doctors. If you are a senior on Medicare, or are lower-income and currently receive your health care through Medicaid, your coverage will also stay the same. However, if you don't work or if your employer doesn't offer health care coverage, you will be eligible for the health insurance exchange. The exchange will include several private options and a public option.

Current Congressional Budget Office (CBO) estimates project that more than 80-percent of participants in the exchange will choose one of the private options. However, the presence of a public option will be good for competition. It will establish minimum coverage standards and prevent private insurers from excluding those with pre-existing conditions or dropping the sick from their rolls.

4. There is nothing in the bill that will lead to rationing health care. Currently, insurance companies make many major health decisions. This bill puts that important power in your hands and your doctors' hands. In other words, insurance companies will no longer be able to ration care by retroactively canceling policies when patients become sick or refuse to cover important services.

5. Offering a public insurance option, as just one of the choices available to consumers, will not crowd out employer-based coverage. However, if we do nothing and costs continue to rise, more employers will be forced to drop coverage. If we reform the system and contain costs, which will help employers, they'll keep offering coverage in order to compete for good workers in competitive labor market.

6. This reform will not cost jobs even though it requires employers to offer health insurance or pay to opt out. Under our current system there is no requirement for employers to offer insurance, yet 99-percent of large firms do and nearly 65-percent of small firms do. For the firms offering coverage already, health reform will bring much needed competition and affordability to the insurance market. In addition, the smallest firms will be exempt. Finally, a 50-percent credit to help pay for premiums will be available for small businesses. In Ohio's Sixth Congressional District, 11,300 small businesses could receive tax credits to help cover their employees.

7. Seniors' coverage under Medicare will actually benefit, not be cut. 9,200 seniors in my district, who currently get caught by the Medicare Part D donut hole in their prescription coverage, will avoid that pitfall because we're closing the hole. In addition, any cost savings by reducing waste, fraud and abuse in Medicare will be reinvested right back into Medicare. These reforms will help modernize the Medicare program and strengthen its financial health, protecting both Medicare beneficiaries and taxpayers. In addition, this bill will eliminate the 21% scheduled reduction in physician payments, which was planned for 2011, ensuring that seniors have access to the doctors they need and deserve.

8. There is a terrible myth being spread that health care reform promotes euthanasia. Not true. If a doctor and a patient choose to have a conversation about end-of-life care and advance care planning, this legislation simply provides Medicare the ability to pay for the doctors' time. This type of counseling is already going on, and doctors should be the ones providing it to patients and families who wish to have it as they face a terminal illness and have to make decisions about pain management and resuscitation. Under the legislation, Medicare will reimburse for the doctor's time once every five years or more often if the patient becomes significantly sicker. However, this legislation does not require that this conversation take place.

9. Finally, staying the course with our current health care system is not an option. Last year, just in my district, nearly 1,300 families had to declare bankruptcy because of health related expenses. Hospitals and doctors in my district provided $89 million to care for the uninsured. That cost was then passed on to those who had insurance, driving up rates. Without reform, the average cost for a family insurance policy increases by $1,800 each year. That means every year it becomes more unaffordable for small businesses to insure their employees and more unaffordable for families to go it alone.

Doing nothing will more than double all of our health costs over the next ten years. That skyrocketing cost will strip millions more Americans of their coverage and it will send our deficit spending through the roof. That is the health care plan we choose by doing nothing.